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The Regulatory Framework in the Healthcare Insurance Industry:
In the Interest of Beneficiaries and Public

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Effective regulatory framework is the key to delivery systems that create a well functioning healthcare environment, this article provides an analysis of the regulatory framework of private health insurance as it relates to the protection of beneficiaries and the public within South Africa context. The Council for Medical schemes (CMS) which is the statutory body established in terms of the Medical Schemes Act 131 of 1998 to provide regulatory oversight to the medical schemes industry in a manner that is complementary with national health policy. Medical schemes that are regulated by the CMS are insurance institutions that cover medical expenses and provide health care insurance in the private sector in South Africa. Medical schemes reimburse their members for actual expenditure on health. A regulatory framework must protect the interests of Beneficiaries, thus CMS continues to effectively engage on regulatory and policy developments in the health and insurance industries to ensure that the rights of South African Beneficiaries are protected at all times.

Introduction

An effective regulatory framework is critical to delivering system reform and to creating a well-functioning healthcare market [13]. This paper presents such a framework within the South African context; we give an outline of goals that a regulation should address. It is important to note that the South Africa's health system consists of a large public sector and a smaller private sector. The public sector is under-resourced and over-used, while the private sector caters to middle- and high-income earners who tend to be members of medical schemes (16% of the population in 2009, not significantly different to the 15% cover by medical schemes in 2000). The demographic structure of medical schemes implies a differently structured health system to that of the general population. This is a worrying factor on the resulting efficiency of the health system as a whole, given the substantial resource allocation bias in favour of the medical scheme market. In 1994, the National Department of Health (DoH) allowed medical schemes, which are primary to paying for private health care, to be regulated [16]. The Medical Schemes Act 131 of 1998 gives the Council for Medical Schemes (CMS) power over medical schemes; the CMS regulates not only medical schemes, but also health insurance brokers, medical scheme administrators and managed care organisations [12]. It also imposes much stricter controls upon medical schemes themselves in terms of corporate governance, financial and membership requirements, and provision of benefits. The Act states the functions of the Council in a far more purposeful and consumer-oriented terms, with a defined focus on the protection of the interests of medical scheme members.

To achieve its regulatory goals, the office of the Registrar participates in the consultative process which aims to demarcate medical schemes from health insurance because it is the case that the encroachment of risk-rated health insurance products into the business of medical schemes results in cream-skimming the young and healthy, unfair discrimination against the old and sickly, and a risk to the sustainability of the medical schemes industry [7]. Another critical element of regulating the private health care sector is to, on an ongoing basis, revise benefit and contribution structures to protect community rating, which is the principle that all beneficiaries on the same benefit option pay the same contribution, and that contributions may vary based only on an individual's income, number of dependants, or both [12]. The regulator of medical schemes is in support of the initiation of a proper consultative and research process towards the development of a regulatory framework for collective bargaining between healthcare providers and funders (including the review of the National Health Amendment Bill).

The Bill was published for comments in 2006 with the final comments at the end of February in 2007. The new draft of the Bill was submitted to the Minister of Health in

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July 2007, and is awaiting discussion and signature of the State President in Parliament. The Bill seeks to address among other key topics the governance issues for medical schemes, including the fit and proper status of trustees. The Bill also seeks to change the manner in which benefits are designed, so as to improve transparency and further reduce incentives for unfair discrimination.

Goals of regulation

The role of market regulation is to facilitate the delivery of overarching policy objectives through economic regulation and consumer protection [13]. The objective of this article is to assess the regulatory framework as it relates to the protection of beneficiaries, thus we focus on the following goals of regulations, the regulatory framework [3].

- Ensuring services (and goods) are safe and of high quality.
- Ensuring fair access to services and (where relevant) also ensure choice of provision.
- Ensuring financial solvency of medical schemes.
- Ensuring transparency and fairness in the contractual relationship between the medical scheme and beneficiary.
- Ensuring that health insurance packages provide adequate financial protection.
- Managing key externalities and by-products of service provision.
- Governance of medical schemes.

Regulation in advanced market economies

The regulatory framework of private health care insurance industries is administered by a government agency or agencies that implement statutory requirements, usually with the authority to establish administrative rules and procedures [9]. This section discuses the some of the regulated activities within the health sector and core functions of such regulating entities.

Licensing of medical schemes, administrators, managed care entities and brokers

A major reason for having regulation is to protect regulated industries from instability and lack of consumer confidence caused by poor administration and trading systems. Setting up minimum registration and accreditation rules and regulations ensures the efficient functioning of market mechanisms. Establishing minimum standards and accreditation rules reduces additional costs of overhead spreads created by artificial market signals that are driven by health insurance administration functions. The Medical Scheme Act gives the CMS regulatory powers over medical schemes, managed care entities, brokers, and administrators. The functions of the CMS are included in Section 7 of the Act. For the purpose of this report, the regulatory functions are expanded using literature on regulatory theory [7]; they are listed are as follows:

Supervising the conduct of registered intermediaries by the Council's line and staff functions, through the implementation of rules-based bureaucratic style of carrying out Council's governance function:

- A managerial approach to the regulator's function of stewardship, controlling conduct by means of quantitative benchmarks and/or qualitative scorecards, monitoring observance to preset specification and performance standards by registered intermediaries
- A collaborative governance approach which allows for a joint learning process in developing health insurance regulatory policy by:
  - configuring formal cooperative interfaces between the regulator's internal operational line functions and staff function (specialist advisors) channels, for the benefit of strengthening the responsiveness of benchmark or peer review policy tools, economic incentives and reducing market uncertainties (market stability and institutional sustainability);
  - Increasing the scope of regulatory transparency and democratizing administrative justice processes by making the Registrar's Office and market information more accessible to medical scheme members

Policing registered institutions in terms of their observance of rules for minimum compliance and mandatory standards intermediaries, such as the observance of:

- Rules of minimum compliance and approval requirements for the registration of medical schemes and other institutions within the regulator's jurisdictional regulatory environment.
- Mandatory compliance standards.
- The regulatory function of: Legal enforcement of provisions emanating from the Act and other forms of precedence, such as behavioural incentives legitimated by enabling rules and guidance notices.
- The regulatory function of: Adjudicating over grievance applications made by medical scheme enrolees.
- The regulatory function of: Educating & Communication of the regulator's fiduciary duty to medical scheme enrolees and, the strengthening of the governance function's role of demonstrating accountability over regulated stakeholder and medical scheme members.
- The regulatory function of: Sanctioning the business of medical schemes and the administration of health insurance business functions.
- The regulatory function of: Observing Fiduciary Obligations arising from Principal-Agent market relationships by, governed schemes and other registered intermediaries and, the Regulatory Body itself.

Solvency Regulation

Solvency regulation includes solvency monitoring, capital requirements, other controls on medical scheme behavior (for example,

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investment regulations) and, in many cases, establishment of beneficiary protection schemes to pay specified claims against insolvent medical schemes [9]. Beneficiaries pay contributions towards medical schemes for future health care spending and the financial capacity for the scheme to respond to claims/ pay for healthcare spending is dependent on the schemes viability and financial soundness. It is of note that the claims can potentially exceed the sum of the total premiums/ contributions received and this is critical to the viability of the scheme.

With solvency regulation, beneficiaries delegate responsibility for monitoring solvency to regulators, as this is also the case in South Africa. Regulatory monitoring might detect medical scheme financial problems early enough to prevent insolvency. In other cases, monitoring can help regulators intervene before the deficit between an insolvent medical scheme's assets and liabilities becomes large. Some degree of regulatory restrictions on medical scheme risk taking (for example, investment limitations and capital requirements) could be efficient for this reason. Solvency is measured in terms of Regulation 29 of the Act. The net assets, after deducting assets set aside for the specific purpose of and unrealized non distributable reserves, are also referred to as "Accumulated Funds". Regulation 29 prescribes the "Minimum accumulated funds" expressed as a percentage of "Gross annual contributions" is referred to as a solvency level.

The Medical Schemes Act requires schemes to maintain a solvency of at least 25% [12].

In the same breath, a solvency level below 25% does not necessarily mean that the scheme is experiencing financial difficulties. Similarly, extremely high solvency levels are not an indication that a scheme is in "perfect" financial position. Figure 1 shows the number of schemes stratified by the (>25%) and (≥25%) stratum. The phasing in of the statutory solvency reserve requirements was from 2000 to 2004, and upward trend in the number of schemes in the ≥25% stratum is seen until 2004, from 2005 a downward trend is observed and the number of schemes in ≥25% stratum declined significantly by 21% from 111 to 88 medical schemes. The declining trend also correlates to the consolidation in the medical schemes environment. There were no significant declines in <25% stratum from 2004 to 2009. Solvency ratio is one indicator used as a benchmark to measure the "financial health" of the scheme and a noteworthy feature of the ratio is that it triggers interventions on the financials of the medical scheme. Thus the regulator of medical schemes consistently monitors solvency levels of medical schemes together with other ratios, such as investment income, non-health expenditure, and membership profile. In ensuring the consumers' willingness to pay contributions for private health insurance, effective regulation requires that schemes are financially sound such that they are able to reimburse their members for the actual expenditure on health.

Benefit option packages, Scheme Rules, Pricing and Risk Selection

Many governments significantly restrict private health insurance pricing and risk selection (underwriting), including imposing limits on rate differentials among different buyers, guaranteed-issue requirements, and guaranteed-renewability rules. Some governments require medical schemes to obtain prior regulatory approval of certain rate changes [9]. In South Africa, the Council is mandated through the Medical Schemes Act 131 of 1998 [12] to approve all the rules before they are implemented by the schemes (s31). The Council also has to ensure that all proposed new benefit options, restructured options, and new schemes, are assessed fully for viability before they are registered in terms of section 33(2). The most important components of section 33 of the Act include the following. A medical scheme:

- May apply for the registration of more than one benefit option.
- Shall be self-supporting in terms of membership and financial performance.
- Is financially sound.
- Will not jeopardize the financial soundness of any existing benefit option within the medical scheme.

Regulation 4 of the Act states that medical scheme rules may provide members of dependants a right to participate in only one benefit option at a time. The referred regulation that scheme rules may provide that members may change options at the beginning of the month of January each year, and by giving written notice of at least three months before such a change is made. It is also stated that a medical scheme must not in its rules, or in any other manner, structure any benefit option in such a manner that creates a preferred dispensation for one or more specific groups of members or provides for the creation of ring-fenced net assets by means of such benefit option. The CMS also approves the amendments of rules to scheme rules and evaluate these in accordance to the required standards; these include mid-year contribution and benefit changes, new options, and the efficiency discounted options for a number of schemes.

Figure 2 illustrates structural differences that exist between open and restricted schemes in terms of benefit options. The 2009 data showed that 40% of restricted schemes, compared to the 3% of open schemes, consisted only of one benefit option. A similar distribution exists in schemes with two benefit options. However this trend is reversed on schemes with four or more benefit options. There are many options in the open schemes environment and this is worrying as each represents a distinct package of benefits, thus members find it difficult to compare products to see which offers the best value for money. Also, as a general rule, the greater the number of benefit options, the greater the costs of providing these benefits. The CMS continues monitor the registration of benefit options, ensuring that they

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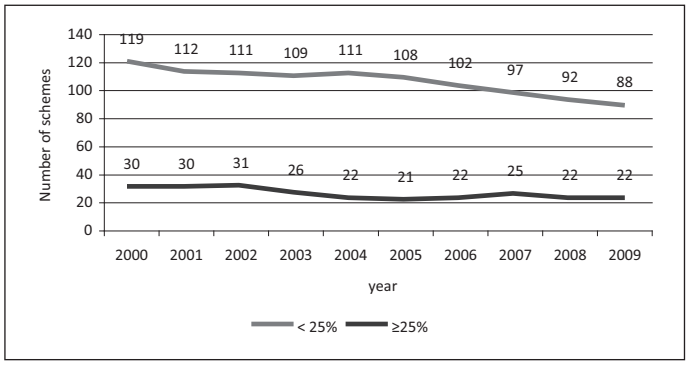

Figure 1. *Industry solvency trends for all schemes (2000–2009)*
Source: [5]

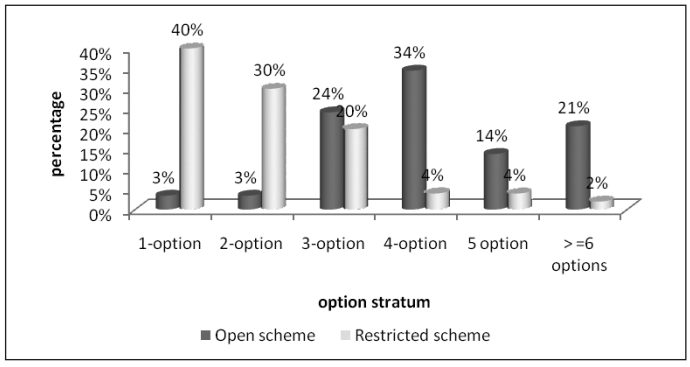

Figure 2. *Distribution of benefit options across medical schemes (2009)*
Source: [21]

are self sustainable, affordable to enrollees, and, indeed, do offer value for money.

Access to minimal level of care

Many governments regulate most language by requiring certain contract provisions and prohibiting others. Some governments mandate minimum coverage provisions [9]. The concept of a minimum level of care is central to the facilitation and achievement of a more equitable and efficient quality health care system in South Africa. The Prescribed Minimum Benefits (PMBs), as provided for by the Medical Schemes Act, have had the greatest importance. PMBs are minimum benefits which, by law, must be provided to all medical scheme members and include the provision of diagnosis, treatment and care costs for:

- any emergency medical condition;
- a range of conditions as specified in Annexure A of the Regulations to the Medical Schemes Act [12], subject to limitations specified in Annexure A; included in this list of conditions are chronic conditions.

PMBs were introduced to avoid incidents where individuals lose their medical scheme cover in the event of serious illness and are put at serious financial risk due to unfunded utilization of medical services. They also aim to encourage improved efficiency in the allocation of private and public health care resources. PMBs are not only legislated, but they are the envisaged platform for the national health insurance package, which defines the entitlement for any person contributing towards such insurance. As a consequence, a package of PMBs with a focus on catastrophic care was developed as Annexure A in the Regulations to the new Act in 2000. In terms of the Regulations, the PMB package was to be reviewed every two years by the DoH. This review must involve the Council for Medical Schemes (CMS), stakeholders, provincial departments of health and consumer representatives.

A review process of PMBs was begun by the Council for Medical Schemes in 2008 [4]. Comments from the stakeholders on the document were taken into account and publication of the third draft of the report in that process was published on the CMS webpage. This process was finalized in 2009/10 and the final draft regulation was submitted to the Minister of Health for consideration for possible publication in the government gazette for public comments. There are, however, challenges with the implementation of the Act and Regulations relating to PMBs. In this regard the CMS continues to engage with the provisions of PMB regulations, including the "payment in full" provisions contained in regulation 8 of the Medical Schemes Act.

Market conduct and unfair trade practices

Insurance regulators often enforce legislation dealing with market conduct and unfair trade practices, such as provisions related to unfair claim settlement practices and potentially deceptive sales practices by medical schemes and administrators [9]. The regulator of the medical schemes in South Africa actively participates in the consultative process which aims to demarcate medical schemes from health insurance. The office of the Registrar is acutely aware that the encroachment of risk-rated health insurance products into the business of medical schemes results in cream-skimming, unfair discrimination, and a risk to the sustainability of the medical schemes industry.

Effective regulation of medical schemes – and the protection of beneficiaries – is critically dependent on all entities and products being subjected to the rigorous oversight and strict protections are contained in the Medical Schemes Act. A serious threat is posed to the sustainability of medical scheme risk pools by the recent proliferation of insurance products which seek to encroach on the preserve of medical schemes. Thus, the CMS continues to participate in the demarcation work group established by National Treasury to draft regulations in support of certain amendments effected to the Long- and Short-Term Insurance Acts

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of 1998 by the Insurance Laws Amendment Act (Act 27 of 2008). The work group comprises stakeholders from industry, government, and regulatory authorities, and has as its purpose consideration of the underlying principles required to inform the drafting of regulations to ensure that a clear delineation of products is achieved so that the purpose of the Medical Schemes Act is not undermined. The differences between the Medical Schemes and Insurance Products is outlined in table 1.

The Medical Schemes Act also states that it is not a good practice to market, advertise or in any other way promote a medical scheme in a manner likely to create the impression that membership of such medical scheme is conditional upon an applicant purchasing or participating in any product, benefit or service provided by a person other than the medical scheme. Thus, it is an offense to conduct practices that are not in line with the scheme rules, and the CMS secures adequate protection for beneficiaries by approving the manner in which medical schemes carry out business, including the products offered by medical schemes and schemes' compliance with Section 21A.

Table 1. *Differences between Medical Schemes and Insurance Products*
Source [16]

Medical Schemes	Insurance Products
Medical Schemes Act 1998	Long Term Insurance Act 1998 and Short Term Insurance Act 1998
Governed by the Council for Medical Schemes	Governed by the Financial Services Board
May not refuse to admit prospective members	Have the right to refuse to insure an individual on the grounds of carrying too high risk
May not make profit	Insures are listed companies which aim to make a profit for their shareholders
Seek to match premiums and benefits paid over the period of a year	Rely on underwriting and actuarial skills to predict future claims experience for given categories of insured persons over long-term
Medical scheme reimburse members for the actual medical expenses	Insurance companies pay policy holders a pre-agreed fixed rate in the event of a claim
Can be paid directly to the provider of the service, a doctor or hospital	Must be paid to the policy holder, not the provider of the service
Registered medical schemes have to provide certain benefits and may not charge a member contributions based on your	Insurance policies may refuse to sell a policy to an individual or may weight premiums according to perceived extra risk. Insurance companies are allowed to evaluate an individual's life style and general state of health before selling a policy for 'dread diseases cover/for example

Information disclosure and consumer complaints

Many governments make available consumer buying guides and other information about medical schemes contracts. In the United States, many jurisdictions provide contribution rate comparisons, and some publish counts of consumer complaints against medical schemes. Section 48 and 49 of the Medical Schemes Act provide that the Council has authority to resolve complaints between medical schemes and their members. This process requires that complaints to be made in writing to the Registrar, who must then pass on the details of the complainant to the party that is subject to the complaint. The party against whom the complaint is made has 30 days in which to respond to the Registrar. The Registrar is required to resolve the dispute or submit it to Council, which is expected to take necessary steps to resolve the complaint. The following are key problem areas in the medical schemes industry, according to an analysis of complaints data in 2010 [6].

- Intermediary behaviour and the functional dimensions of the registered entities were identified as one of the key problem areas that need to be addressed and monitored closely.
- Lack of product quality and standardization is a policy problem is caused by external factors, related to capitalizing on opportunities to take advantage of un-priced risk positions by market participants.
- Fiduciary duties of intermediaries, duty to disclose and/or unilateral mistake vs. moral hazard and risk-selection are complaints are largely related to non-clinically related entitlements. Undesirable conduct is due to incomplete markets and characteristics of such markets creating barriers to accessing healthcare. These were identified as one of the biggest changes that threaten the systematic sustainability in the industry.
- Conduct inducing market uncertainty is one of the contributing factors that relate to systematic sustainability in the industry. These complaints relate to the restructuring of financial & operating capital and contingencies impacting risk hazards in market environment.
- Clinical treatment, formularies and protocols were also identified as one of the key problem areas dealing with the systematic sustainability in the medical schemes industry. Section 29(1) & Annexure A of the regulation of the Medical Schemes Act 131 of 2008 is to be used as a base or control measure for clinical treatment, formularies and protocols related types of complaints.

The data analyzed by the CMS showed that social regulation, which also relates to

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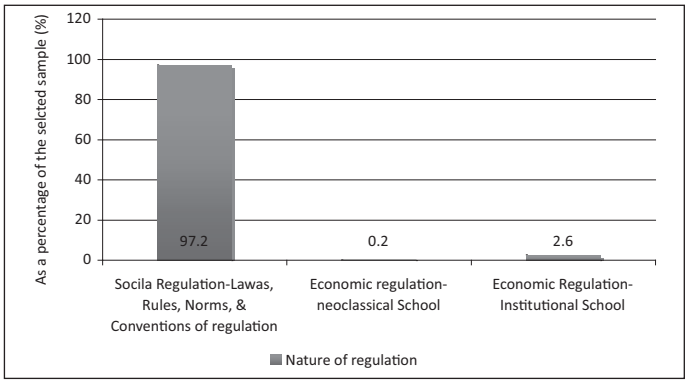

Figure 3. *Nature of regulation classification*
Source: [6]

Laws, Rules, and Norms & Conventions of Regulatory Institutions (456/469, 97.2%), is most dominant in the medical schemes environment. Social Regulation [14] typically focuses on policy levers that enhance consumer welfare interventions within specific policy environments, thus the paternalistic and normative values of regulatory philosophy inform how regulators protect the interests of consumers. There was a significantly a small number of complaints that relate to Economic Regulation – Institutional School (1/469, 0.2%) and Economic regulation – neoclassical school (12/469, 2.6%).

In keeping with the Act's emphasis on complaints, in 2009, the Council embarked on a process of revamping the complaints system that captures complaints. This was to ensure an efficient and accessible, complaints processing system that will be an instrumental tool of health system policy analysis through strengthening the responsiveness of policy levers to consumer needs and the advocacy of consumer interests.

The Governance of Health Insurance

The Medical Schemes Act imposes strict controls upon medical schemes themselves in terms of corporate governance in ensuring the protection of beneficiaries. The framework for medical scheme corporate governance is derived from the common law, King II and the Medical Schemes Act of 1998. A major challenge facing all trustees, including medical aid trustees, is to act "with due care, diligence and the utmost good faith". Section 29 of the Act sets out certain minimum requirements to be contained in the rules of a medical scheme, with a view to protecting the interests of members and also providing a framework for good governance. In terms of section 24(2) of the Medical Schemes Act [12], no medical scheme shall be registered unless the Council is satisfied that members of the board of trustees and the principal officer of the proposed medical scheme are fit and proper persons to hold the office concerned.

The statutory duties of the board of trustees of a medical scheme, however, derive primarily from the provisions of section 57 of the Act. These include: appointment of the principal officer; accountability for operations of the scheme and resolutions passed by the board; ensuring that proper control systems are in place; communication to members on rights, benefits, contributions, and duties in terms of rules of the scheme; ensuring timely payment of contributions to the scheme; procuring professional indemnity insurance and fidelity guarantee insurance; obtaining expert advice on legal, accounting, and business matters as required; ensuring compliance with the Act; and protecting the confidentiality of member information. Ongoing governance failures among medical schemes prompted the Council for Medical Schemes to undertake a project to review their governance practices and to identify the key determinants of governance failures. The findings and recommendations of the Council's "Governance Theme Project" were released in mid 2006, to recommend additional strategies to improve medical scheme governance and to mitigate the risk of governance failure.

Out-of-pocket payments

Out-of-pocket health expenditures represent a significant burden on households globally. Most private health expenditure comprises out-of-pocket payments for health care, and this includes user fees or co-payments for insurance covered services, payments for health service not covered by the insurance and informal payments to providers. Private health expenditure accounted for 40% of total health spending in the EAC countries compared to the 27% in countries that are members of the Organization for Economic Cooperation and Development (OECD). In Latvia, out-of-pocket expenditure for health care represented 4.7% of household expenditure [20].

Health services funded by medical schemes only benefit the 15% of the population who were members of these schemes in 2000; this figured moved slightly to 16% in 2009. Medical schemes cover 16% of the population; this population uses the private sector on an out-of-pocket basis for primary care but is almost entirely dependent on the public sector for hospital care [11]. The total household expenditure in South Africa in 2007 was R148.5 billion. 19% of this was the out-of-pocket payments, which means that the spending over and above the medical schemes contributions was R28 billion [16]. The figures presented in the figure 4 below show South Africa as the second lowest out-of-pocket expenditure with reference to other countries.

The Medical Schemes Act lays down the minimum benefits beneficiaries should receive from their medical scheme; these are benefits that schemes must by law pay for in "full". Earlier in 2009, a task team on the

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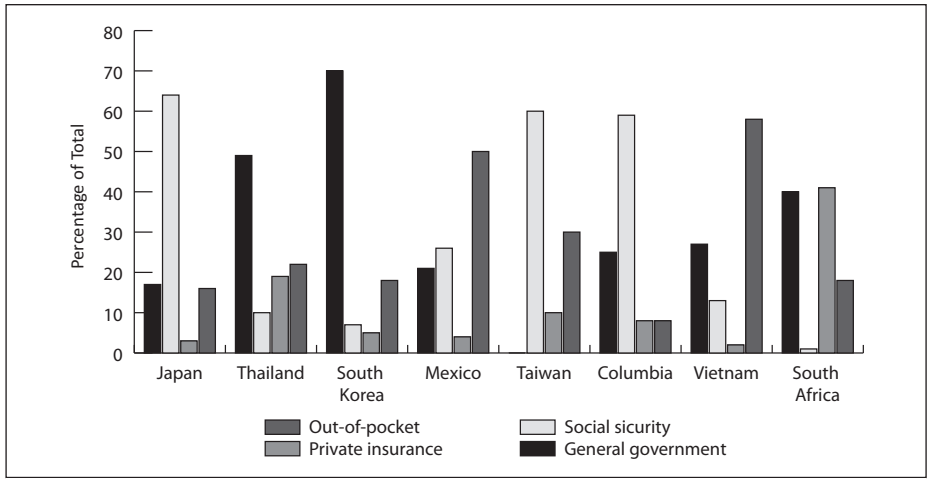

Figure 4. *Out-of-pocket payments (Country comparisons)*
Sources: [22]

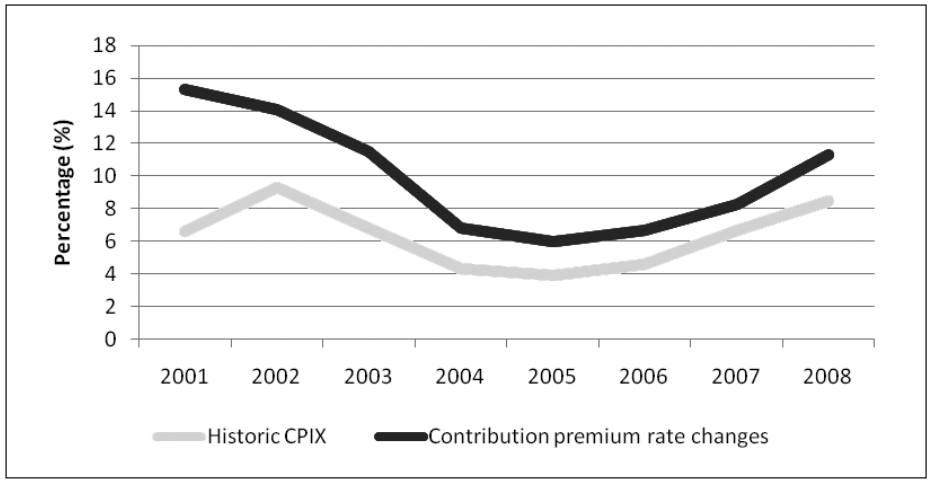

Figure 5. *Contribution rate changes (2001–2008)*
Source: [5]

PMBs was set up by the Registrar composed of the Council for Medical Schemes, medical schemes, healthcare providers and patient rights groups, who are working on clarifying how the PMBs are defined and (at the time of writing this article) this process was still in progress. The outcome of this process could result in schemes becoming liable for more healthcare costs; the successful implementation of PMB could possibly offer members the potential to save on out-of-pocket expenses and contribution costs.

Contribution increases

Increases in excess of the CPI create an affordability challenge for beneficiaries because medical scheme contributions comprise a larger proportion of household expenditure. When the pricing of benefit options increases it is often followed by a downward migration of beneficiaries to cheaper benefits options. Contribution increases are monitored by the CMS on annual basis to ensure the affordability of premiums by beneficiaries. The average increase in contributions per option is compared to a benchmark of CPIX + 3%. Options that reflect increases greater than this benchmark are requested to provide further justification for their increase. This is used as a guideline by the office to ensure that contribution increases are justified and fall within a reasonable range.

The nominal increase in average risk contributions per average beneficiary (as per scheme financials) from 2006/2007 was 9.9% and the comparing figure for period 2009/2010 was 11.6% for the open schemes market, which was slightly higher than the restricted schemes. The average increase for restricted scheme in gross contribution per average beneficiary per month was 3.9% for 2006/7 and the comparing figure for 2009/10 was 11.6%. The contribution increases proposed by the schemes in 2009/10 were 15.7% (a deviation of 4.1% from the actual) for the open schemes and 12.7% for the restricted schemes (a deviation of 1, 1% from the actual). The considerable difference between these estimated contribution increases and the actual increase in the average contribution income of schemes indicates that some beneficiaries bought down from more comprehensive options to cheaper options, with the consequent dampening effect on contributions. This phenomenon is more pronounced in open schemes than the restricted schemes. The CMS vigorously investigates the contribution increases and also monitors the affordability and access to healthcare within the medical schemes industry, which is done through the cost containing strategies.

Non-healthcare costs and contribution increases

Accredited entities, including medical schemes, administrators, brokers and managed care entities do not always act in the best interests of scheme members and the public at large. "Many schemes and administrators attempt to influence brokers to

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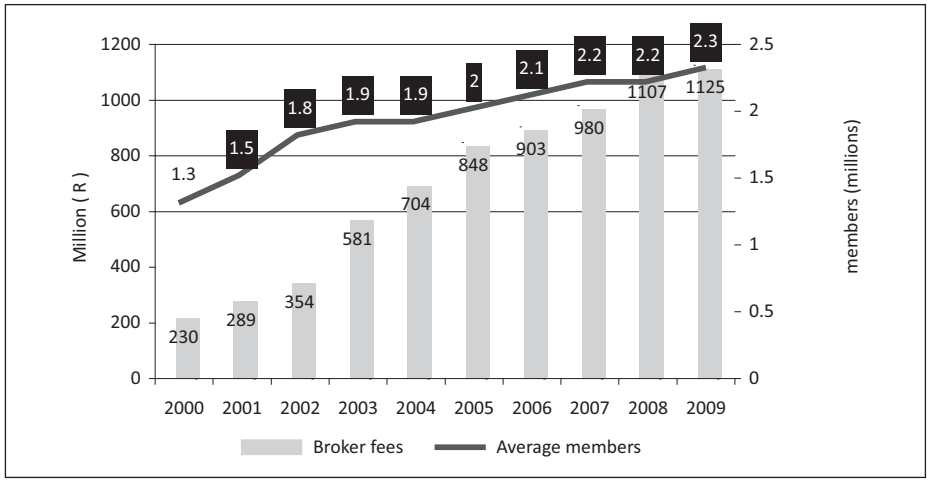

Figure 6. *Broker fees and scheme membership*
Source [5]

advise clients to choose a particular scheme by bidding up broker commissions. This was what largely necessitated the regulated capping of broker fees from 2004. However, the regulatory regime still has loopholes allowing conflicts of interest to exist by permitting schemes to pay the fees in respect of advice to members. The conflicts substantially reduce the quality of advice in the market and permit schemes to avoid being wholly responsive to members and beneficiaries", [4]. Figure 6 illustrates the increase in broker fees relative to membership of schemes that pay brokers. Broker service fees have been rising sharply over the past few years, resulting in rates of increase now far exceeding the increases in number of members. For those schemes that paid brokers, broker service fees PAMPM (per average member per month) increased by 169.6% since 2000 compared with an 81.6% net increase in the average number of members. The substantial increases in broker service fees are not proportional to the increase in new members in the medical schemes environment [5], and this poses questions whether the brokers are indeed adding value to the medical schemes. The CMS has started initiate consultative processes to propose the revision of the regulatory framework for the remuneration of healthcare brokers.

Expanding coverage and health work force

Regulated private insurance coupled with various social health insurance options and government subsidies represent the middle-income country route toward building a universal system. There has been a lot discussion about introducing National Health Insurance (NHI) in South Africa. "The first phase of the project will be rolled out in 2012, and will focus primarily on bringing services to areas with little or no access to quality healthcare and thereafter be extended to other areas of the country. Providing universal coverage for all South Africans, irrespective of whether they are employed or not should aim to ensure equity and solidarity among the population through the pooling of risks and funds. The NHI calls for mandatory membership for all South Africans through mandatory contributions and social solidarity, it is up to the general public to continue with additional voluntary cover with the medical schemes after they have contributed to the NHI Fund" [1]. Private health insurance plays a large and increasing role around the world and it is envisaged that even in South Africa the medical schemes could be an important component of achieving universal coverage. One possibility is envisaged in which medical schemes continue to operate in an NHI setting and function as a supplementary cover; this is, of course, with reference to the international experiences and is also dependent on definition of the NHI package. A word of caution is to learn from the international experiences, so as to mitigate the shortcomings of establishing such a fund and also to be aware of the different characteristics between countries.

As South Africa prepares for the implementation of the NHI, one of the key challenges that needs to be addressed relates to the health work force. "There is a massive global shortage of health workers and these are most intensely in developing countries, the reasons for shortage in health workforce are multitude including underproduction, misdistribution of health workforce, health workforce exit and increase in demand of health care. Many countries in the world with acute shortage of health workforce face a lack of medical schools. For an instance, two thirds of sub-Saharan African countries have only one medical school and some have none" [17]. The number of nurses in South Africa, as estimated by the WHO, is 18000 and these professionals are serving a population of nearly 49 million. This translates to 3.8 per 1000 patients – significantly smaller than the 9.4 and 7.7 per 100 patients in the US and Canada respectively [16]. The national shortage of health care workers is critical to the implementation of the NHI and key areas of attention for the initial roll-out of the NHI are being discussed. These include investing and rebuilding the country's public health infrastructure, developing human resources programs to fill the national shortage of qualified health workers, and establishing a national health fund that would be ensconced in the Ministry of Health but operate autonomously. The CMS' expertise and 10 years of experience can also play a vital role in making NHI Fund work efficiently.

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Conclusions

The ultimate responsibility for the overall performance of a country's health system lies with government, which, in turn, should involve all sectors of society, promoting the spirit of cooperation and partnerships among private and public health professionals. A government has the responsibility for establishing the best and fairest health system possible with available resources and the oversight and regulation of private sectors, which must form part of the overall government response, must be high on the policy agenda.

Regulation of private health insurance should not only provide oversight to private health insurance companies but it should also focus on encouraging demand for coverage and otherwise facilitating the entry and expansion of access to health care. This will then result in an environment where a greater proportion of the citizens of the country have access to good quality healthcare. In the South African context, the private sector is critical to the implementation of the NHI fund, and policy makers need to confront the role that private health insurance will play. Regulatory approaches and policies can structure private health insurance markets in ways that mobilize resources for health care, promote financial risk protection, protect consumers, and reduce inequities. Regulatory frameworks for private health insurance need to be structured in such a way that they regulate the sector appropriately so that it serves public goals of universal coverage and equity

Effective regulation ensures the protection of beneficiaries and includes a critical responsibility to ensure financial solvency of the schemes. This is achieved by establishing risk-based solvency and minimum capital standards to mitigate risk for the insured population and employers. The rationale for an effective regulation framework should mandate disclosure requirements for policies and costs requiring that their content is understandable to consumers and that the consumers are informed of their rights. Promoting equity involves ensuring access to health care by all income strata of the population, and minimizing risk skimming and adverse selection, which distort health insurance markets, and this is also a key policy goal for effective regulation. Government policy needs to provide a framework that result in coverage for a minimum level of essential services, irrespective of whether it is provided in the public or the private sectors. Given the existence of perverse incentives in unregulated markets for health care, any regulation must pay careful attention to the incentives generated. The use of mixed systems for covering and providing health care, combined with the correct elements of choice, is the best approach to balancing health care objectives with the need for operational efficiency.

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